MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit
1426 Howe Avenue
Sacramento, California 95825
1-800-633-2322
(916) 263-2424 – Fax (916) 263-2435

CONSUMER COMPLAINT FORM

Instructions for Filing Your Complaint

- ✓ Fill in the full name and address, telephone number, license number (if known) of the person your complaint is against. Also write this information in the first section of the Authorization for Release of Medical Records on the reverse side of the Complaint Detail Form.
- ✓ If the patient has seen another doctor for the **same** problem, include the name, address and date(s) of treatment on the release section of the complaint form.
- ✓ Write your complaint and include as many specific details as possible (who, what, when, where, why). Include the date(s) of treatment and specific examples of the problems with the care and treatment and use extra sheets of paper, if needed. Send us copies of any documents in support of your complaint which may include patient records, photographs, audiotapes, correspondence, billing statements, proof of payments, etc.
- ✓ Sign and date the complaint form at the bottom of the page and on the Authorization Release Form.

Authorization for Release of Medical Information

The Authorization for Release of Medical Information found on the reverse side of the Complaint Details form is a legal authorization for the Medical Board's staff to obtain information about the patient's care from the doctors and/or medical facilities involved in the medical care. **ANY EXTRA COMMENTS, NOTATIONS, ETC. MAKE THE FORM VOID AND WE WILL HAVE TO ASK YOU TO COMPLETE ANOTHER RELEASE FORM.** If you wish to provide us with additional information, please do so using a separate sheet of paper. If there are more than four physicians or medical facilities, you may copy the blank form in order to have enough spaces. When this form is completed and signed, it allows the Medical Board to order records from **ONLY** the doctors or facilities you have listed on the medical record release form.

Print or **type** the patient's name, date of birth, date of death, and medical record number if applicable. If we need to contact you to clarify your information, it will delay the review process. FILL IN THE FULL NAME AND ADDRESS OF THE PERSON YOU ARE COMPLAINING ABOUT IN THE FIRST SECTION. Fill in the names and addresses of all other health care providers where the patient was seen for the medical problems **in this specific complaint** (doctors and/or clinics or hospitals, etc**.)** using the other sections on the medical release.

NOTE: The release form must be signed and dated **by either the patient or the individual legally authorized to make medical decisions for the patient.** If the patient is unable to sign the release, the form may be signed by: 1) the next of kin, if the patient is deceased (provide a copy of the Death Certificate); 2) the parent of a minor child; or 3) the person named by the patient in a signed Power of Attorney granting the person authority to make **medical decisions** for the patient (provide a copy of this document).

MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM

PERSON REGISTERING THE COMPLAINT

Please Print or Type

☐ Mr. ☐ Ms.

Name: _____
(Last Name) (First Name) (M.I.)

Mailing Address: _____

_____
(City) (State) (Zip)

Phone Number: _____
(Daytime Number) (Evening Number) (Cell phone/E-mail address)

☐ Mr. ☐ Ms.

Patient Name: _____
(Last Name) (First Name) (M.I.)

Patient Date of Birth: _____ **Your Relationship to Patient:** _____

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page

☐ **Substandard Care** (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)

☐ **Prescribing Issues** (e.g., excessive/under prescribing, Internet)

☐ **Unlicensed Provider orAiding/Abetting unlicensed practice**

☐ **Sexual Misconduct**

☐ **Physician/Provider Impairment** (e.g., Drug, Alcohol, Mental, Physical)

☐ **Unprofessional Conduct** (e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)

☐ **Office Practice** (e.g., Failure to Provide Medical Records to Patient, Failure to Sign Death Certificate, Patient Abandonment)

Other_____

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of State Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Office.

I wish to complain about the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

Check one:

☐ **Physician (M.D.)** ☐ **Podiatrist (DPM)** ☐ **Physician Assistant (PA)** ☐ **Registered Dispensing Optician (RDO)** ☐ **Midwife** ☐ **Unlicensed Provider**

COMPLAINT REGISTERED AGAINST **Please Print or Type**

Name: _____
(Last Name) (First Name) (M.I.)

Office/Facility Name: _____ **License No.** (If known): _____

Street Address: _____
(Address) (City) (State) (Zip Code)

Phone Number: **( )** _____

Has the patient been examined/treated by another professional for this same condition?

☐ **No** ☐ **Yes** **If yes, provide name and address on the Authorization for Release of Medical Information**

Reason for Treatment: _____

Date(s) of Treatment: _____

DETAILS OF COMPLAINT

(Attach additional sheets if necessary)

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF
PATIENT HEALTH INFORMATION

Patient Name:_____

Medical Record No._____ Date of Birth: _____
(If applicable)

Social Security No.:_____ Date of Death: _____
(Optional) (If applicable)

I, the undersigned hereby authorize: (*Please list one Physician or Facility in a separate box*)

Physician_____
(Last Name) (First Name) (M.I.)

Address_____

Phone Number(s)_____Treatment Date(s)_____

Physician/Facility_____

Address_____

Phone Number(s)_____Treatment Date(s)_____

Physician/Facility_____

Address_____

Phone Number(s)_____Treatment Date(s)_____

Physician/Facility_____

Address_____

Phone Number(s)_____Treatment Date(s)_____

to provide records in the course of my diagnosis and treatment, including medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) to the **MEDICAL BOARD OF CALIFORNIA, ENFORCEMENT PROGRAM,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Medical Board of California of the State of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Medical Board of California, 1426 Howe Avenue, Ste. 93, Sacramento, CA, 95825. My written revocation will be effective upon receipt by the Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Signature: _____ _____
Patient Date

or

_____ _____
Legal Representative Relationship Date

NOTE TO THE PROVIDER: Failure by a physician, podiatrist or health care provider to provide the requested records within 15 days, or health care facility in 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action of the Board. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.